PBP 2003 USER INSTRUCTIONS

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INTRODUCTION

The Plan Benefit Package (PBP) software is composed of the PBP Management Screen and four sections: A, B, C, and D. These sections collect data concerning general organization and plan information, benefits descriptions, access and dual eligible information, and premium and optional supplemental benefits information, respectively.

Based on comments received from MCOs and changes in Medicare policy, CMS has continued to modify the PBP to improve the collection and display of the data.

PBP SOFTWARE FEATURES

PART A/B PLANS VERSUS PART B ONLY PLANS

Inpatient hospital and SNF services are not covered by Medicare for Part B Only beneficiaries. Therefore, the data collected in these benefit categories for the Part B Only plans differs from that data collected for the Part A/B plans.

RED VERSUS BLUE VARIABLES

Data variables in the PBP are either red or blue. A red variable indicates that this information will be used to generate the Standardized Summary of Benefits (SB) sentences that are used in marketing materials and in Medicare Health Plan Compare (MHPC). Blue variables do not impact either the SB or MHPC.

HELP

The PBP has Help features throughout the system. At any time, by right clicking the mouse, the variable help, directions, and definitions can be accessed.

IMPORTING TEXT

Importing text into a notes field in the PBP from a document such as Microsoft Word can be accomplished two ways. The user may select the text from another document, copy, and then paste the selected text into the PBP Notes field by pressing the <Ctrl> and <v> keys simultaneously. Alternatively, the user may save the document to be put into the PBP as a text file and then use the Import Text button in the PBP to import this text file into the PBP Notes field.

PBP SOFTWARE ENHANCEMENTS AND POLICY CLARIFICATIONS

This section highlights software enhancements and also provides CMS policy clarifications for completing the PBP.

COST SHARE AMOUNTS

Cents can be entered with dollars in all fields that collect monetary amounts, including Copayments, Deductibles, Maximum Plan Benefit Coverage, Maximum Enrollee Out-of-Pocket Costs, and Premium amounts.

POINT-OF-SERVICE (POS)

The questions regarding whether the plan offers a point-of-service benefit are in Section B-19. This location corresponds to Health Component #19 in the ACR. This section will not be enabled if the plan type is HMO.

VISITOR/TRAVEL (V/T) BENEFIT

In Section A of the PBP, the plan must indicate if it includes a V/T program; and, if a V/T benefit is included, the MCO must describe the program in the Section A Notes.

REFERRAL VERSUS AUTHORIZATION

The question, "Is a referral required for …?" has been added in most service categories, and the SB sentences concerning referrals will be generated from these questions. Generally, a referral is defined as an actual document obtained from a provider in order for the beneficiary to receive additional services, whereas, authorization is defined as notification or approval to receive a service.

MAXIMUM PLAN BENEFIT COVERAGE

Maximum Plan Benefit Coverage is only applicable for service categories where there are enhanced benefits being offered by the plan, because Medicare coverage does not allow a Maximum Plan Benefit Coverage expenditure limit.

COINSURANCE VERSUS DISCOUNT

When entering cost sharing information, discounts should be entered as coinsurance and not described in the Notes. For example, if an MCO offers a discount of 20% for prescription drugs, provided that this is a benefit with a direct cost in the ACR, then the MCO should enter a 80% coinsurance in the PBP. This will display the appropriate information in the Summary of Benefits.

MINIMUM/MAXIMUM COST SHARES

Throughout the PBP, minimum/maximum (min/max) cost sharing amounts are collected. Min/max cost sharing questions exist in certain categories because the cost sharing for an item or service could vary. When a min/max cost share is required, the SB sentence that is generated will display either the range of cost sharing values or the single cost share amount. For example, if the min/max fields are filled out as $0 and $5, the SB sentence generated will read, "You pay $0 to $5 for….". If the min/max fields both contain $5, the SB sentence generated will read, "You pay $5 for….".

PERIODICITY

Periodicity within the PBP is generally presented as five or six options, including every six months, every year, every two years, etc. Although this accommodates many plan benefit

structures, it cannot accommodate all structures. Therefore, CMS has provided for an "other" periodicity to be entered. If the benefit plan periodicity is not specifically listed, i.e., every 18 months, the option "other" should be selected. CMS has made changes in the SB sentences when the option "other" is selected that provides language which is more appropriate. See the SB crosswalk for this language.

ZERO COST SHARE VALUES

If there is no cost sharing for benefits in a category, i.e., no coinsurance and no copayment, the questions "Is there an enrollee Coinsurance?" and "Is there an enrollee Copayment?" should both be answered "No". By answering "No" to both these questions, the PBP will generate the following SB sentence, "There is no copayment for [particular service]". If the MCO wants to generate the sentence "You pay $0 for [particular service]", then the MCO should answer the copayment question "Yes" and enter a "0" for the copayment amount.

OPTIONAL SUPPLEMENTAL STEP-UP BENEFITS

If a plan offers multiple levels of a benefit, i.e., a basic benefit and an elevated version (a.k.a. a step-up), then information on Optional Supplemental Step-up Benefits for ten selected service categories may be entered in Section D. The screens for these categories contain the same questions as those for the category in Section B.

Specifically, if an enhanced benefit is offered as both an Additional or Mandatory Supplemental and as an Optional Supplemental benefit, the Additional or Mandatory Supplemental benefit should be described in the data fields within the PBP service category in Section B. For ten selected categories, the Optional Supplemental Step-up benefit should be described entirely in Section D. For other categories, it should be described in the Notes field for that service category in Section B. NOTE: The MCO should NOT describe or enter Step-up benefits in PBP Service Categories B-13c, B-13d, or B-13e.

Example: Prescription drugs are offered as a Mandatory Supplemental benefit with a maximum limit of $500 per year. The MCO also offers Prescription Drugs as an Optional Supplemental benefit with a limit of $1500 per year. To describe these two benefits, the MCO should complete the Outpatient Prescription Drug screens describing the $500 limit. The Optional Supplemental benefit with a $1500 limit should be entered in Section D. Section D also collects information on packaging and pricing the Optional Supplemental benefits.

The ten Optional step-up benefit categories are:

- Chiropractic Services (7b)
- Podiatrist Services (7f)
- Transportation Services (10b)
- Outpatient Drugs (15)
- Dental - Preventative Services (16a)
- Dental - Comp. Svcs (16b)
- Vision - Eye Exams (17a)
- Vision - Eye Wear (17b)
- Hearing - Hearing Exams (18a)
- Hearing - Hearing Aids (18b)

PBP SECTION/SERVICE CATEGORY AND SB ISSUES

SECTION A

Information contained in Section A consists primarily of high level MCO and Plan information, including the H and Plan ID numbers, type of plan, name of the plan, and geographic area of the plan. This data has two sources: HPMS and the PBP. Many data elements in Section A are downloaded from HPMS after the MCO has "created" a plan and are disabled ("grayed out") in the PBP. If changes need to be made to these data, please refer to "Editing Plan Specific Information" in the Downloading chapter of these instructions. The data entry contact information was deleted.

Beginning in CY 2003, MCOs will be able to use their adjusted excess to reduce the Medicare Part B premium for beneficiaries. When offering this benefit, a plan cannot reduce its payment by more than 125 percent of the Medicare Part B premium. As a result, the PBP system must validate the "indicate your MCO plan payment reduction amount, per member" field to ensure that the number entered is not greater than 125 percent of the Medicare Part B premium. Since the Medicare Part B premium for 2003 will not be released until the fall of 2002, the PBP (and ACR) will use an estimated 2003 Medicare Part B premium amount.

In order to calculate the Part B premium reduction amount, the PBP system must multiply the number entered in the "indicate your MCO plan payment reduction amount, per member" field by 80 percent. The resulting number is the Part B premium reduction amount for each member in that particular plan (rounded to the nearest multiple of 10 cents). This rounded number will then be used to populate the corresponding SB sentence describing the Part B premium reduction benefit.

The Introduction to the Summary of Benefits has been revised based on plan type.

SECTION B

B-1a: Inpatient Hospital—Acute

Below are the instructions for entering data if a plan has cost sharing on a per day basis.

Medicare Covered Stay Cost Shares: If a plan has a per day cost structure for Medicare-covered stays, the plan must explicitly price the 90 days covered by Medicare during a benefit period. To ensure this pricing structure, the software requires the user to enter, at a minimum, a start day equal to '1' in the first interval, and an end day equal to '90' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Example: If a MCO charges $100 per day with a maximum of $500 per stay, the MCO should declare two intervals and enter the copayment as $100 for Days 1 through 5 and $0 for Days 6 through 90.

NOTE: Medicare's lifetime reserve days are not explicitly described in the cost-sharing, since the use of lifetime reserve days is at the discretion of the beneficiary and not assigned by the plan. Any information concerning lifetime days should be described in the Notes section of Inpatient Hospital Acute.

Additional Days Cost Shares: Additional days are defined as days covered by the plan after the 90 Medicare-covered days per benefit period. Additional days for Inpatient Hospital Acute should always start at day 91. The number of additional days offered will determine the end day. The SB 2003 includes two new sentences if Additional Days is offered as an Additional or Mandatory benefit and 1) there is no cost sharing; or 2) there is only one interval associated with a cost.

Example: If 10 additional days per benefit period are offered, then the cost share structure should specify additional days 91 through 100. If an unlimited number of additional days are offered, "999" should be used to notate the end day of the pricing structure. By using "999", the SB will generate a sentence that states "You pay $x for additional days 91 and beyond."

Non-Medicare Covered Stay Cost Shares: A non-Medicare-covered stay is a stay that is not medically necessary and reasonable according to Medicare coverage guidelines, or is provided in a facility not certified by Medicare. If the plan has a per day cost share for the Non-Medicare-covered stay, the first day of the cost share interval must be day 1 and the last day must be the maximum number of days covered under the benefit. As in the case of the Medicare-covered stay, all days must be explicitly priced for the non-Medicare covered stay, if a per day cost share structure exists. The SB 2003 includes a new sentence if a Non-Medicare covered stay is offered as an Additional or Mandatory benefit and there is only one interval associated with a cost.

Example: If the plan charges $50 per day for an unlimited Non-Medicare-covered Stay, then the MCO should declare one interval and enter $50 for days 1 through 999.
If the Medicare Covered cost-sharing and Non-Medicare Covered cost sharing are the same, answer "Yes" to the question, "Is the Copayment [Coinsurance] structure for the Non-Medicare Covered stay the same as the Copayment [Coinsurance] structure for the Medicare Covered stay?". By answering "Yes", the correct SB sentences will be produced, eliminating unneeded duplication of sentences.

General issue concerning Inpatient Substance Abuse:
Inpatient Substance Abuse may be covered either under Inpatient Hospital Acute or Inpatient Psychiatric Hospital. The MCO may use either subcategory to describe it in the PBP.

B-1b: Inpatient Hospital—Psychiatric

In the PBP 2003, the Original Medicare interval structure has changed from 1-190 days to 1-150 days.

Below are the instructions for entering data if a plan has cost sharing on a per day basis.

Medicare Covered Stay Cost Shares: If a plan has a per day cost structure for Medicare-covered stays, the plan must explicitly price the 190 days covered by Medicare. To ensure this pricing

structure, the software requires the user to enter, at a minimum, a start day equal to '1' in the first interval, and an end day equal to '190' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Example: If a MCO charges $100 per day with a maximum of $500 per stay, the MCO should declare two intervals and enter the copayment as $100 for Days 1 through 5 and $0 for Days 6 through 190.

Additional Days Cost Shares: Additional days are defined to be days covered after the 190 Medicare-covered days. Additional days for Inpatient Psychiatric Hospital should always start at day 191. The number of additional days offered will determine the end day. The SB 2003 includes two new sentences if Additional Days is offered as an Additional or Mandatory benefit and 1) there is no cost sharing; or 2) there is only one interval associated with a cost.

Example: If 10 additional days per benefit period are offered, then the cost share structure should specify additional days 191 through 200. If an unlimited number of additional days are offered, "999" should be used to notate the end day of the cost share structure. By using "999", the SB will generate a sentence that states "You pay $x for additional days 191 and beyond."

Non-Medicare Covered Stay Cost Shares: A non-Medicare-covered stay is a stay that is not medically necessary and reasonable according to Medicare coverage guidelines, or is provided in a facility not certified by Medicare. If the plan has a per day cost share for the Non-Medicare-covered stay, the first day of the cost share interval must be day 1 and the last day must be the maximum number of days covered under the benefit. As in the case of the Medicare-covered stay, all days must be explicitly priced for the non-Medicare covered stay, if a per day cost share structure exists. The SB 2003 includes a new sentence if a Non-Medicare covered stay is offered as an Additional or Mandatory benefit and there is only one interval associated with a cost.

Example: If the plan charges $50 per day for an unlimited Non-Medicare-covered Stay, then the MCO should declare one interval and enter $50 for days 1 through 999.

If the Medicare Covered cost-sharing and Non-Medicare Covered cost sharing are the same, answer "Yes" to the question, "Is the Copayment [Coinsurance] structure for the Non-Medicare Covered stay the same as the Copayment [Coinsurance] structure for the Medicare Covered stay?". By answering "Yes", the correct SB sentences will be produced, eliminating unneeded duplication of sentences.

General issue concerning Inpatient Substance Abuse:
Inpatient Substance Abuse may be covered either under Inpatient Hospital Acute or Inpatient Psychiatric Hospital. The MCO may use either subcategory to describe it in the PBP.

B-2: Skilled Nursing Facility (SNF)

In the PBP 2003, the following two questions were added for Part B Only plans:

- Is a hospital stay required before admission to a SNF?"
- If yes, then "Indicate number of days required for hospital stay"

Below are the instructions for entering data if a plan has cost sharing on a per day basis.

Medicare Covered Stay Cost Shares: If a plan has a per day cost structure for Medicare-covered stays, the plan must explicitly price the 100 days covered by Medicare during a benefit period. To ensure this pricing structure, the software requires the user to enter, at a minimum, a start day equal to '1' in the first interval, and an end day equal to '100' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Example: If a MCO charges $100 per day with a maximum of $500 per stay, the MCO should declare two intervals and enter the copayment as $100 for Days 1 through 5 and $0 for Days 6 through 100.

Additional Days Cost Shares: Additional days are defined to be days covered after the 100 Medicare-covered days per benefit period. Additional days for SNF should always start at day 101. The number of additional days offered will determine the end day. The SB 2003 includes two new sentences if Additional Days is offered as an Additional or Mandatory benefit and 1) there is no cost sharing; or 2) there is only one interval associated with a cost.

Example: If 10 additional days per benefit period are offered, then the cost share structure should specify additional days 101 through 110. If an unlimited number of additional days are offered, "999" should be used to notate the end day of the pricing structure. By using "999", the SB will generate a sentence that states "You pay $x for additional days 101 and beyond."

Non-Medicare Covered Stay Cost Shares: A non-Medicare-covered stay is not medically necessary and reasonable according to Medicare coverage guidelines, or is provided in a facility not certified by Medicare. If the plan has a per day cost share for the Non-Medicare-covered stay, the first day of the cost share interval must be day 1 and the last day must be the maximum number of days covered under the benefit. As in the case of the Medicare-covered stay, all days must be explicitly priced for the non-Medicare covered stay, if a per day pricing structure exists. The SB 2003 includes a new sentence if a Non-Medicare covered stay is offered as an Additional or Mandatory benefit and there is only one interval associated with a cost.

Example: If the plan charges $50 per day for an unlimited Non-Medicare-covered Stay, then the MCO should declare one interval and enter $50 for days 1 through 999.

If the Medicare Covered cost-sharing and Non-Medicare Covered cost sharing are the same, answer "Yes" to the question, "Is the Copayment [Coinsurance] structure for the Non-Medicare Covered stay the same as the Copayment [Coinsurance] structure for the Medicare Covered stay?". By answering "Yes", the correct SB sentences will be produced, eliminating unneeded duplication of sentences.

General issue concerning Skilled Nursing Facility:
Medicare requires a prior 3 day inpatient hospital stay and an admission to a SNF within 30 days of the inpatient discharge, to be a qualifying SNF stay. If the MCO admits a beneficiary who does not meet these requirements to a SNF, it is a non-Medicare covered SNF stay and must be

described and priced accordingly in the PBP and ACR as an Additional, Mandatory or Optional Supplemental benefit.

B-3: Comprehensive Outpatient Rehabilitation Facility (CORF)

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-4a: Emergency Care/Post Stabilization Care

For a cost share that is waived upon immediate admittance from the ER to the hospital: MCOs often waive the coinsurance and/or copayment for the emergency room visit if a beneficiary is admitted to the hospital. If the cost share is waived, the question "Is the Coinsurance [Copayment] for Medicare Covered Benefits waived if admitted to hospital?" should be answered "Yes" and the appropriate days or hours in which the admission must occur for the waiver should be entered. If the waiver is only applicable when the beneficiary is immediately admitted to the hospital, then "hours" should be selected and the number "0" should be entered as the number of hours in which admittance must occur for the cost-sharing to be waived. This will produce the sentence, "You do not pay this amount if you are immediately admitted to the hospital."

B-4b: Urgently Needed Care/Urgent Care Centers

For a cost share that is waived upon immediate admittance to the hospital: MCOs often waive the coinsurance and/or copayment for the urgent care center visit if a beneficiary is admitted to the hospital. If the cost share is waived, the question "Is the Coinsurance [Copayment] for Medicare Covered Benefits waived if admitted to hospital?" should be answered "Yes" and the appropriate days or hours in which the admission must occur for the waiver should be entered. If the waiver is only applicable when the beneficiary is immediately admitted to the hospital, then "hours" should be selected and the number "0" should be entered as the number of hours in which admittance must occur for the cost-sharing to be waived. This will produce the sentence, "You do not pay this amount if you are immediately admitted to the hospital."

B-5: Partial Hospitalization

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-6: Home Health Services

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-7a: Primary Care Physician Services

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-7b: Chiropractic Services

Medicare Covered Chiropractic Services only include Manual Manipulation of the Spine to Correct Subluxation. Any other Chiropractic Services that are offered would be considered routine care and would be classified as either Additional, Mandatory Supplemental, or Optional Supplemental benefits.

In the SB, Manual Manipulation of the Spine and Chiropractic Services (Routine care) are merged into one category, "Chiropractic Services". The SB sentences will continue to distinguish between the Manual Manipulation of the Spine and Routine Care.

B-7c: Occupational Therapy Services

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-7d: Physician Specialist Services

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-7e: Mental Health Specialist Services

Cost sharing allows plans to enter self-designated intervals for costs per visit. Below are the instructions for entering data if a plan has cost sharing on a per visit basis.

Individual/Group Visit Cost Shares: If a plan has a per visit cost structure for individual and/or group visits, the plan should explicitly price these visits. Since the visits are Medicare-covered, the plan should enter a start visit equal to '1' in the first interval, and an end visit equal to '999' in the last interval. Note that the end visit can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Example: If an MCO charges $10 per visit for the first 10 visits, then $25 per visit for all visits beyond 10, the MCO should declare two intervals and enter the copayment as $10 for Visits 1 through 10 and $25 for Visits 11 through 999.

Example: If an MCO charges $10 per visit for the first 10 visits, then $25 per visits 11-20, then 50% coinsurance for all visits beyond 20, the MCO should declare three intervals for both copayment and coinsurance. The copayment intervals would be $10 for Visits 1 through 10, $25 for Visits 11 through 20, and $0 for Visits 21 through 999. The coinsurance intervals would be 0% for Visits 1 through 10, 0% for Visits 11 through 20, and 50% for Visits 21 through 999. This structure will ensure proper sentences print out in the SB.

If the cost sharing for both individual and group visits are the same, ensure that the cost sharing structure is entered exactly the same for both the individual and group visits. By doing so, one SB sentence will be produced for both types of visits, thereby eliminating unnecessary duplication.

B-7f: Podiatry Services

Medicare Covered Podiatry Services only include medically necessary and reasonable foot care. Any other Podiatry Services that are offered would be considered routine care and would be classified as either Additional, Mandatory Supplemental, or Optional Supplemental benefits.

In the SB, Medically Necessary Foot Care and Podiatry Services (Routine care) are merged into one category, "Podiatry Services". The SB sentences will continue to distinguish between the Medically Necessary Foot Care and Routine Care.

B-7g: Other Health Care Professional Services

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-7h: Psychiatric Services

Cost sharing allows plans to enter self-designated intervals for costs per visit. Below are the instructions for entering data if a plan has cost sharing on a per visit basis.

Individual/Group Visit Cost Shares: If a plan has a per visit cost structure for individual and/or group visits, the plan should explicitly price these visits. Since the visits are Medicare-covered, the plan should enter a start visit equal to '1' in the first interval, and an end visit equal to '999' in the last interval. Note that the end visit can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Example: If a MCO charges $10 per visit for the first 10 visits, then $25 per visit for all visits beyond 10, the MCO should declare two intervals and enter the copayment as $10 for Visits 1 through 10 and $25 for Visits 11 through 999.

Example: If an MCO charges $10 per visit for the first 10 visits, then $25 per visits 11-20, then 50% coinsurance for all visits beyond 20, the MCO should declare three intervals for both copayment and coinsurance. The copayment intervals would be $10 for Visits 1 through 10, $25 for Visits 11 through 20, and $0 for Visits 21 through 999. The coinsurance intervals would be 0% for Visits 1 through 10, 0% for Visits 11 through 20, and 50% for Visits 21 through 999. This structure will ensure proper sentences print out in the SB.

If the cost sharing for both individual and group visits are the same, ensure that the cost sharing structure is entered exactly the same for both the individual and group visits. By doing so, one SB sentence will be produced for both types of visits, thereby eliminating unnecessary duplication.

B-7i: Physical Therapy and Speech-Language Pathology Services

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-8a: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Services

In the PBP2003, the cost shares for clinical services and diagnostic services have been combined into one cost share. The SB 2003 sentences for clinical services and diagnostic services have also been changed accordingly.

In the SB 2003, the category for Radiation Therapy has been eliminated, and the sentences for therapeutic radiation have been inserted into the category for Diagnostic Tests, X-rays and Lab services.

B-8b: Outpatient X-Rays

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-9a: Outpatient Hospital Services

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-9b: Ambulatory Surgical Center Services

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-9c: Outpatient Substance Abuse Services

Cost sharing allows plans to enter self-designated intervals for costs per visit. Below are the instructions for entering the cost share structure if a plan has cost sharing on a per visit basis.

Individual/Group Visit Cost Shares: If a plan has a per visit cost structure for individual and/or group visits, the plan should explicitly price these visits. Since the visits are Medicare-covered, the plan should enter a start visit equal to '1' in the first interval, and an end visit equal to '999' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Example: If a MCO charges $10 per visit for the first 10 visits, then $25 per visit for all visits beyond 10, the MCO should enter the copayment as $10 for Visits 1 through 10 and $25 for Visits 11 through 999.

Example: If an MCO charges $10 per visit for the first 10 visits, then $25 per visits 11-20, then 50% coinsurance for all visits beyond 20, the MCO should declare three intervals for both copayment and coinsurance. The copayment intervals would be $10 for Visits 1 through 10, $25 for Visits 11 through 20, and $0 for Visits 21 through 999. The coinsurance intervals would be 0% for Visits 1 through 10, 0% for Visits 11 through 20, and 50% for Visits 21 through 999. This structure will ensure proper sentences print out in the SB.

If the cost sharing for both individual and group visits are the same, ensure that the cost sharing structure is entered exactly the same for both the individual and group visits. By doing so, one SB sentence will be produced for both types of visits, thereby eliminating unnecessary duplication.

B-9d: Cardiac Rehabilitation Services

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-10a: Ambulance Services

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-10b: Transportation Services

If transportation services are not offered, the category will not appear on the SB.

B-11a: DME

Benefit information contained in the DME Services category includes all DME not related to Diabetes Monitoring Supplies.

B-11b: Prosthetics and Medical Supplies

In the PBP 2003, a cost share specifically for Medical Supplies has been added. Data entered in the cost sharing fields of category 11b-Prosthetics and Medical Supplies should only include data for Prosthetic Devices. There is no corresponding sentence for Medical Supplies in the SB.

B-11c: Diabetes Monitoring Supplies

This category distinguishes between Diabetes Monitoring Supplies and other DME, since cost sharing often differs between these two categories. Benefit information for Diabetes Training should continue to be entered in category 14i-Diabetes Monitoring. SB sentences will distinguish between Diabetes Monitoring Training and Diabetes Monitoring Supplies.

B-12: Renal Dialysis

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-13a: Outpatient Blood

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-13b: Acupuncture

If acupuncture services are not offered, the category will not appear on the SB.

B-13c: Other1

The category, "Other1" should be used to describe benefits that are not provided for in other areas of the PBP, such as a massage benefit. This category should not be used to provide information on benefits that are listed in other areas such as the Hepatitis B vaccine. In addition, optional supplemental benefits and "step-ups" (see section on policy clarifications and changes for step-ups) should not be described in this category.

B-13d: Other2

The category, "Other2" should be used to describe benefits that are not provided for in other areas of the PBP, such as a massage benefit. This category should not be used to provide information on benefits that are listed in other areas such as the Hepatitis B vaccine. In addition, optional supplemental benefits and "step-ups" (see section on policy clarifications and changes for step-ups) should not be described in this category.

B-13e: Other3

The category, "Other3" should be used to describe benefits that are not provided for in other areas of the PBP, such as a massage benefit. This category should not be used to provide information on benefits that are listed in other areas such as the Hepatitis B vaccine. In addition, optional supplemental benefits and "step-ups" (see section on policy clarifications and changes for step-ups) should not be described in this category.

B-14a: Health Education/Wellness

If no Health Education/Wellness services are offered, the category will not appear on the SB. The SB 2003 has eliminated the cost share sentences for the benefits in this category.

B-14b: Immunizations

The Immunization category on the SB does include some automatically generated sentences (see SB 2003 Crosswalk).

If there is no cost sharing for immunizations but a doctor office copayment does or may apply, the coinsurance/copayment questions for immunizations should be marked "No" while the question, "Indicate whether a separate office visit cost share applies for services:" should be marked either "Yes" or "Sometimes, describe". Multiple copay sentences will not be generated in the SB provided the cost sharing for the immunization is marked "No."

B-14c: Routine Physical Exam

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-14d: Pap and Pelvic Exams

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

If there is no cost sharing for Pap and Pelvic Exams but a doctor office copayment does or may apply, the coinsurance/copayment questions for Pap and Pelvic Exam should be marked “No” while the question, “Indicate whether a separate office visit cost share applies for services:” should be marked either “Yes” or “Sometimes, describe”. Multiple copay sentences will not be generated in the SB, provided the cost sharing for the Pap and Pelvic Exam is marked "No."

B-14e: Prostate Cancer Screening

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

If there is no cost sharing for Prostate Cancer Screenings but a doctor office copayment does or may apply, the coinsurance/copayment questions for Prostate Cancer Screening should be marked “No” while the question, “Indicate whether a separate office visit cost share applies for services:” should be marked either “Yes” or “Sometimes, describe”. Double copay sentences will not be generated provided the cost sharing for the Prostate Cancer Screening is marked "No."

B-14f: Colorectal Cancer Screening

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

If there is no cost sharing for Colorectal Cancer Screenings but a doctor office copayment does or may apply, the coinsurance/copayment questions for Colorectal Cancer Screening should be marked “No” while the question, “Indicate whether a separate office visit cost share applies for services:” should be marked either “Yes” or “Sometimes, describe”. Multiple copay sentences will not be generated in the SB, provided the cost sharing for the Colorectal Cancer Screening is marked "No."

B-14g: Bone Mass Measurement

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

If there is no cost sharing for Bone Mass Measurements but a doctor office copayment does or may apply, the coinsurance/copayment questions for Bone Mass Measurement should be marked "No" while the question, "Indicate whether a separate office visit cost share applies for services:" should be marked either "Yes" or "Sometimes, describe". Multiple copay sentences will not be generated in the SB, provided the cost sharing for the Prostate Cancer Screening is marked "No."

B-14h: Mammography Screening

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

If there is no cost sharing for Mammography Screening but a doctor office copayment does or may apply, the coinsurance/copayment questions for Mammography Screening should be marked "No" while the question, "Indicate whether a separate office visit cost share applies for services:" should be marked either "Yes" or "Sometimes, describe". Multiple copay sentences will not be generated in the SB, provided the cost sharing for the Mammography Screening is marked "No."

B-14i: Diabetes Monitoring

Diabetes Monitoring, 14i, is specifically designed for diabetes monitoring training. Diabetes supplies should be entered in category 11c, Diabetes Monitoring Supplies.

In the PBP 2003, the plan is required to provide benefit information for Nutrition Therapy in the Notes.

B-15: Outpatient Prescription Drugs

For plans that indicated that they do not offer non-formulary drugs unless it is medically necessary: If the plan indicates that non-formulary drugs are not offered, then another question is enabled that asks the plan if non-formulary drugs are provided ONLY if medically necessary. The plan should select "Yes" or "No", and may describe any details in the Notes field. Answering "Yes" to this question does not require any further data entry for non-formulary drugs.

A separate set of questions enables a plan to describe a limit on the entire drug benefit. If the plan indicates that it has a maximum plan benefit coverage, then the plan must designate if there is an overall limit, a limit on a combination of drug types, and/or limit(s) on individual drug types.

Example: The plan offers Formulary (Brand and Generic) drugs and has a $500 annual limit on Brand and unlimited Generic drugs. The plan would designate that it has a maximum plan benefit coverage, and that this includes Individual drug types. Under Formulary-Brand, the plan would indicate that there is a maximum plan benefit coverage of $500 annually, and under Formulary-Generic, the plan would indicate that there is NO maximum plan benefit coverage.

Example: The plan offers Formulary (Brand and Generic) drugs and has a $750 annual limit on the combination of drugs, but unlimited Generic after the limit is reached. The plan would designate that it has a maximum plan benefit coverage, and that this includes Combination of drug types. The plan would select Formulary Brand and Formulary Generic for the combination, and enter an overall limit of $750 annually. The plan would then indicate that Generic is unlimited after the combined max is reached.

Example: The plan has a $3,000 annual limit on drugs, with a $1,000 annual limit on Formulary-Brand and Non-Formulary Brand combined, and no individual limit on Formulary-Generic and Non-Formulary Generic. The plan would designate that it has a maximum plan benefit coverage, and that this includes All drug types covered by plan AND Combination of drug types. The plan would enter an overall limit of $3,000 annually, and a combination limit of $1,000 annually that includes Formulary-Brand and Non-formulary Brand in the combination.

In addition, if a plan only offers drugs with no distinction between formulary and non-formulary, the MCO should only answer questions relating to non-formulary drugs. SB sentences will be generated that will not distinguish between formulary and non-formulary when the data is entered in this manner.

Authorization questions remain in the Prescription Drug Category. Written prescriptions from a physician are not considered to be an authorization for this category.

There is only one Notes field for this category that is located on Screen 5.

B-16a: Preventive Dental Services

The MCO can have a single cost share for an Office Visit and designate the enhanced benefits that are included in that Office Visit.

Example: If the plan offers Oral Exams, Fluoride Treatments, Cleanings, and X-rays, and an Office Visit costs $80 and is comprised of an Oral Exam, Fluoride Treatment, and Cleaning, then under the Copayment, the MCO should select "Yes" to the question, "Is there a combination of services included in a single cost per office visit?". The MCO should then select Oral Exams, Fluoride Treatments, and Cleanings for the combination, and then enter $80 as the copayment amount for the office visit. Since the plan also offers X-rays, the cost sharing for this benefit should be entered separately.

The SB includes bullets describing the benefits that are included in the Office Visit.

B-16b: Comprehensive Dental

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-17a: Eye Exams

Data elements in the Eye Exam and Eye Wear categories allow for a maximum plan benefit coverage for either eye wear, eye exams, an individual maximum plan benefit coverage for each category, or a combined maximum plan benefit coverage for both categories.

Example: An MCO offers a $150 annual maximum plan benefit coverage for eye care. This includes both 17a-Eye Exams and 17b-Eye Wear. In 17a-Eye Exams Base 1, select “Yes” to “Is there a service-specific Maximum Plan Benefit Coverage amount?”, enter $150 and select "Every year". In 17b-Eye Wear Base 3, select “Yes” to “Is there a service-specific Maximum Plan Benefit Coverage amount?”, and for the next question, “Select the Maximum Plan Benefit Coverage type”, select the option “Covered under Eye Exams Category 17a”.

B-17b: Eye Wear

Data elements in the Eye Exam and Eye Wear categories allow for a maximum plan benefit coverage for either eye wear, eye exams, an individual maximum plan benefit coverage for each category, or a combined maximum plan benefit coverage for both categories.

Example: An MCO offers a $150 annual maximum plan benefit coverage for eye care. This includes both 17a-Eye Exams and 17b-Eye Wear. In 17a-Eye Exams Base 1, select “Yes” to “Is there a service-specific Maximum Plan Benefit Coverage amount?”, enter $150 and select "Every year". In 17b-Eye Wear Base 3, select “Yes” to “Is there a service-specific Maximum Plan Benefit Coverage amount?”, and for the next question, “Select the Maximum Plan Benefit Coverage type”, select the option “Covered under Eye Exams Category 17a”.

B-18a: Hearing Exams

There are no 2003 PBP Section/Service Category or SB issues for this category.

B-18b: Hearing Aids

For enhanced benefits, the plan may select Hearing Aids (all types) OR one or more of the individual types of aids (Inner Ear, Outer Ear, and/or Over the Ear). If Hearing Aids (all types) is selected, then the MCO may NOT select an individual type of aid. There is a min/max cost share available for the plan to price Hearing Aids (all types).

B-19: POS

The POS category includes pick lists to enable the MCO to indicate which service categories include a POS benefit and, in addition, which of those categories require a referral and which require authorization.

If the plan indicates that there is a cost share for the POS benefit, the PBP allows the MCO to indicate if the POS costs are the same as non-POS, or if they are different by entering a Min/Max range. There are separate cost share questions for Inpatient Hospital Acute and Inpatient Psychiatric Hospital benefits, if applicable.

SECTION D

Designation of Optional Supplemental Benefits Package

Section D is used to designate Optional Supplemental Benefits packages offered by the plan. Section D enables the plan to create one or more Optional Supplemental Benefit packages with an associated premium.

The plan selects one or more benefit subcategories enabled on the first screen based on benefits designated as Optional in Section B. Each enabled subcategory must be included in at least one Optional Supplemental Benefit package. In addition, the MCO may also select, on a second screen, other service categories containing optional supplemental benefits within a designated package. Optional supplemental benefits for ten selected categories (indicated by an asterisk *) must then be selected on the third screen for data entry. The data entry screens for these ten step-up benefits are similar to the screens in Section B. If the package includes a step-up benefit that is not one of these ten, then the plan must describe the step-up benefit in the category Notes in Section B.

The ten Optional step-up benefit categories are:

- Chiropractic Services (7b)
- Podiatrist Services (7f)
- Transportation Services (10b)
- Outpatient Drugs (15)
- Dental - Preventative Services (16a)
- Dental - Comp. Svcs (16b)
- Vision - Eye Exams (17a)
- Vision - Eye Wear (17b)
- Hearing - Hearing Exams (18a)
- Hearing - Hearing Aids (18b)

The MCO must enter the Premium amount for the Optional Supplemental Benefits package and select from the pick lists on screens 1 and 2 the set of service categories that describe the optional supplemental benefits included in that package. Note that a service category should

only be selected once between the two screens, so it is not repeated in the list of service categories included in the package.

UPLOAD

Certification Statement

There is no longer a certification statement provided.

Summary of Benefits Verification

Upload requires a verification of the Summary of Benefits. This verification serves two purposes. The APV tool requires the Summary of Benefits to be generated in order to review and verify the two documents (Introduction and Matrix). In addition to the use in the APV tool, the verification of the SB produces the document for upload into MHPC.

CMS CONTACTS

Plan Benefit Package General Questions

Jermaine Staggers	410-786-1958
Christine Perenich	410-786-2987

Summary of Benefits

Camille Brown	410-786-0274

Evidence of Coverage

Wendy Burger	410-786-1566
Deborah Long	214-767-4458

Medicare Health Plan Compare

Valerie Hartz	410-786-6013

HITS User ID

Neetu Balani	410-786-2548
Don Freeburger	410-786-4586

Adjusted Community Rate

Theresa Conrad	410-786-7635
Kristin Finch	410-786-2873

HPMS

Lori Robinson	410-786-1826
Pamela Nicholson	410-786-0263

HPMS Help Desk 1-800-220-2028